

Medical Insurance	EMPLOYEE CONTRIBUTION 2026-2027	EMPLOYER CONTRIBUTION 26-27	
	Cost per Month	Cost per Month	
EPO3			
SINGLE	\$135.44	\$948.08	
EMPLOYEE + EMPLOYEE	\$234.97	\$1,644.78	only 1 employee pays
EMPLOYEE + SPOUSE	\$542.24	\$1,337.52	
EMPLOYEE + CHILDREN	\$419.91	\$1,276.04	
EMPLOYEE+ EMPLOYEE + FAMILY	\$537.67	\$2,144.72	only 1 employee pays
EMPLOYEE + FAMILY	\$874.95	\$1,807.44	
POS 4			
SINGLE	\$93.77	\$948.08	
EMPLOYEE + EMPLOYEE	\$162.67	\$1,644.78	only 1 employee pays
EMPLOYEE + SPOUSE	\$469.94	\$1,337.52	
EMPLOYEE + CHILDREN	\$354.68	\$1,276.04	
EMPLOYEE+ EMPLOYEE + FAMILY	\$434.50	\$2,144.72	only 1 employee pays
EMPLOYEE + FAMILY	\$771.78	\$1,807.44	
HDHP			
SINGLE	\$52.09	\$948.08	
EMPLOYEE + EMPLOYEE	\$90.37	\$1,644.78	only 1 employee pays
EMPLOYEE + SPOUSE	\$397.64	\$1,337.52	
EMPLOYEE + CHILDREN	\$289.45	\$1,276.04	
EMPLOYEE+ EMPLOYEE + FAMILY	\$331.33	\$2,144.72	
EMPLOYEE + FAMILY	\$668.61	\$1,807.44	only 1 employee pays

OPTIONAL ADDITIONS for LCSD INSURANCE -

DENTAL INSURANCE

Additional cost per month

SINGLE	\$37.75
FAMILY	\$109.41

VISION INSURANCE -

Additional cost per month

SINGLE	\$4.75
FAMILY	\$12.12



Lake County School District
Learning Beyond Walls

*All insurance selections and changes are through the [EASE](#) insurance portal.

Lake County School District		Medical benefits at a glance	
Medical Plan Name	EPO 3	POS 4	HDHP 5
Benefits¹	In Network Single/Family	In Network Single/Family	In Network Single/Family
Deductible	Single \$1000/Family \$2000	Single \$2,000/Fam \$4,000	Single \$3,000/Family \$6,000
Preventive Care	No charge	No charge	No charge
Office Copay (PCP/SPC)	PCP \$40, SPC \$55	PCP \$40, SPC \$40	20% coins after deductible
Hospital Inpatient Care	\$1000 copay + 20% coins	20% coins after deductible	20% coins after deductible
Urgent Care	\$50 copay	20% coins after deductible	20% coins after deductible
Emergency Room	\$250 copay	20% coins after deductible	20% coins after deductible
X-Ray and Lab	Lab \$40 / X-Ray \$50	Lab \$40 / X-Ray 20% coins	20% coins after deductible
Diagnostics (CT/PET,MRI)	\$500 Visit	20% coinsurance	20% coins after deductible
Out-of-Pocket	Single \$3,000/Family \$6,000	Single \$4,500/Family \$9,000	\$12,000/\$24,000
INN Pharmacy (Only)	\$20/\$40/\$60; 2xs Mail Order	\$20/\$40/\$60; 2xs Mail Order	After Deductible \$20/\$40/\$60
Out of Network	EPO 3	POS 4	HDHP 5
Deductible	Not Covered	\$4,000/\$8,000	\$6,000/\$12,000
Coinsurance	Not Covered	40%	40%
Out of Pocket	Not Covered	\$10,000/\$20,000	\$12,000/\$24,000
Employee Costs	EPO 3	POS 4	HDHP 5
	Monthly	Monthly	Monthly
Employee	\$135.44	\$93.77	\$52.09
Employee + Spouse	\$542.24	\$469.94	397.64
Employee + Children	\$419.91	\$354.68	\$289.45
Employee + Family	\$874.95	\$771.78	\$668.61
Employee+Employee	\$234.97	\$162.67	\$90.37
EE + EE + Children	\$537.67	\$434.50	\$331.33

All Insurance changes are through the EASE portal. Please contact Human Resources for any questions on enrollment. Benefits start 07/01/2026.





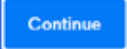
Enrollment Guide at a Glance

1. Log in to Ease per the instructions you have received from your HR administrator or Broker. For optimal performance it is recommended that you use

Chrome  or Firefox  as your browser.

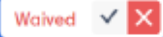
2. Click  to begin your enrollment.

3. Follow the prompts on each page to complete your benefit enrollment.

Click  to proceed to the next section.

4. Verify your personal information is correct and enter in any of your dependent information.

5. If requested during the enrollment process, provide any emergency contacts, employment documents, Medicare status, previous/current coverage and/or health information.

6.  your benefit by selecting  or  for each plan.

Click  to proceed to the next benefit.

7. You will then be prompted to provide any missing data. Once you have done this, you will be able to review and sign your forms using your mouse or mobile device. 

8. Before you review your forms



type your name.

THEN

Sign your signature



and follow the prompts to finish.

9. If you have questions, reach out to your HR administrator or Broker.



A Quick Look at Your Health Plan

Lake County School District

Group #16035

When you enroll with Meritain Health[®], you're taking the next step towards a healthier, more balanced you.

It's important for you to understand how your health plan works. This way, you can make the changes you want in your health and in your life.

Get the support you need for a healthy balance

Chances are, you try every day to keep a healthy balance in your life. But time can get away from you, or you might put other details first. That's why we're here: to help you focus and to support you each step of the way. You can think of your health care benefits as your resource to protect your body, mind and spirit.

Benefit Highlights

Protecting your healthy balance with preventive care

Q

Question:

Which is better: Taking an hour or two out of your busy day to have your annual checkup—or missing hidden symptoms and paying the price in sick days, copays and missed events?

A

Answer:

Nothing makes more sense in these busy times than preventing illness before it happens. That's why your plan offers excellent benefits for preventive services.

Early detection, proper nutrition, and routine exercise are the keys to living a long and healthy life, and will also help to control long-term health care costs. Your employer encourages you to take the necessary steps—available to you right now—to ensure early detection and treatment of diseases.



Built into your health plan are preventive benefits that cover:

- Bone density test.
- Fecal occult screening.
- Mammogram.
- Pap smear.
- Physical exams.
- Prostate blood exam.
- Well-child care.

Save when you visit network providers

This plan offers a network of doctors and other health care professionals who have agreed to accept lower amounts than their standard charges, just for members of this plan. These lower amounts are negotiated and predetermined. That means when you see a network provider, your share of costs is based on a lower charge—so your costs are lower, too. Network providers are conveniently located in both urban and rural areas. Lower costs and convenient doctors and clinics are important ways that Meritain Health can support your efforts to stay well and have a healthy lifestyle—or to get care as simply as possible when you're sick.

Remember: if you go outside the network, you may still have benefits, but your share of costs will be higher, and the amount you pay will not be based on a lower rate.

Benefit Highlights

File claims quickly and easily

If you visit a provider in your network, you shouldn't need to submit a claim for services or pay at the time of your service with the exception of a copay, if applicable. Your provider will submit the claim on your behalf and you will later receive a bill for any out-of-pocket or other balances due.

If you have visited an out-of-network provider, you may need to file a claim form to ensure that the service is billed properly. Claim forms can be found online at www.meritain.com or you can obtain one from your Human Resources department. Submit the claim by fax or by mail to the fax number or mailing address listed on the claim form.

Support for your health journey

Your employer wants you to get the best, most appropriate care, when and where you need it. That's why your plan includes the extra expertise of **Meritain Health's Medical Management Program**. The Medical Management nurses are like personal health consultants who can help you make decisions about certain types of care you and your doctor may be considering. Registered nurses review treatment plans, then help to assure that you get the right treatment in the right setting, when you need it.

Some of these services include:

- Before admission to the hospital for elective or non-emergency services.
- Within 48 hours (two working days) after an emergency or urgent hospital admission.
- Before elective inpatient, outpatient or ambulatory surgery.
- Before inpatient substance-abuse treatment or treatment for a mental health disorder.
- Before entering an extended-care, rehabilitation or skilled-nursing facility.

Consult your Summary Plan Description for a complete listing of health care services that require precertification with a medical management nurse.

Benefit Highlights

Nationwide provider access at a discount

When you and your family seek health care services, you have access to Aetna's broad national provider network of health care providers and facilities. Aetna's network contains more than 664,000 participating physicians and ancillary providers, with 5,667 hospitals.¹ When you visit providers in the Aetna network, you will receive services at strong, negotiated rates, helping you to save on the cost of health care.

Locate your preferred providers

With Aetna's comprehensive provider participation, many of your preferred doctors may already be in the Aetna network. To verify whether or not a doctor or health care facility participates, visit <https://www.aetna.com/dsepublic/#/mymeritain>.



How to access your mobile web app

iPhone®

- Once you log in to your member website through www.meritain.com, click the  icon at the bottom of the page.
- Then, scroll through the menu options and select *Add to Home Screen*.
- Click *Add* in the upper right-hand corner.
- Your Meritain Health app logo will then be installed and added to your home screen.
- Then, you'll be able to log in through the app instead of going through the website.

Android™

- Once you log in to your member website through www.meritain.com, you'll be prompted with the pop-up message *Add Meritain Health to Home Screen* at the bottom of the page. Click this message.
- Then, you can click *Add* to add the logo to the home page or *Cancel* to opt-out.
- Your Meritain Health app logo will then be installed and added to your home screen.
- Launch the app from your home screen and log in.

Not all services are covered. See plan documents for a complete description of benefits, exclusions and limitations of coverage. Providers are independent contractors and are not agents of Meritain Health. Provider participation may change without notice. Meritain Health and Aetna do not provide care or guarantee access to health services.

¹ <https://www.aetna.com/about-us/aetna-facts-and-subsidiaries/aetna-facts.html>

Benefits Summary

	EPO Plan 3	PPO Plan 4	
	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
MAJOR MEDICAL			
Deductible (Ded)	\$1000/Individual \$2000/Family	\$2,000/Individual \$4,000/Family	\$4,000/Individual \$8,000/Family
Out-of-Pocket Maximum (Including Deductible, Copayments & Coinsurance)	\$3,000/Individual \$6,000/Family	\$4,500/Individual \$9,000/Family	\$9,000/Individual \$18,000/Individual
Co-Insurance	80%	80%	60%
PREVENTIVE CARE	100%, Deductible Waived	100%, Deductible Waived	90% after Deductible
PHYSICIANS OFFICE VISITS	\$40	\$40	60% after Deductible
SPECIALIST OFFICE VISITS	\$55	\$40	60% after Deductible
URGENT CARE	\$50	80% after Deductible	60% after Deductible
EMERGENCY ROOM	\$250, then 100%	80% after Deductible	Paid at In Network
HOSPITAL INPATIENT CARE	\$1000 copay per admission	80% after Deductible	60% after Deductible
HOSPITAL OUTPATIENT CARE	\$750 copay per visit	80% after Deductible	60% after Deductible
PRESCRIPTION DRUG CARD			
Retail (31 days supply)	Generic	\$20.00	NA
	Preferred	\$40.00	NA
	Non-Preferred	\$60.00	NA
Mail Order (up to 90 days supply)	Generic	\$40.00	NA
	Preferred	\$80.00	NA
	Non-Preferred	\$120.00	NA

Benefits Summary

	HDHP Plan 5	
	IN-NETWORK	OUT-OF-NETWORK
MAJOR MEDICAL		
Deductible (Ded)	\$3,000/Individual \$6,000/Family	\$6,000/Individual \$12,000/Family
Out-of-Pocket Maximum (Including Deductible, Copayments & Coinsurance)	\$6,000/Individual \$12,000/Family	\$12,000/Individual \$24,000/Individual
Co-Insurance	80%	60%
PREVENTIVE CARE	100%, Deductible Waived	90% after Deductible
PHYSICIANS OFFICE VISITS	80% after Deductible	60% after Deductible
SPECIALIST OFFICE VISITS	80% after Deductible	60% after Deductible
URGENT CARE	80% after Deductible	60% after Deductible
EMERGENCY ROOM	80% after Deductible	Paid at In Network
HOSPITAL INPATIENT CARE	80% after Deductible	60% after Deductible
HOSPITAL OUTPATIENT CARE	80% after Deductible	60% after Deductible
PRESCRIPTION DRUG CARD		
Retail (31 days supply)	Generic	80% after Deductible
	Preferred	80% after Deductible
	Non-Preferred	80% after Deductible
Mail Order (up to 90 days supply)	Generic	80% after Deductible
	Preferred	80% after Deductible
	Non-Preferred	80% after Deductible
		NA
		NA
		NA
		NA
		NA
		NA

Your Guide to Enrollment



Completing your enrollment

Complete, sign and return your enrollment form to your employer within 30 days of your eligibility date whether you're enrolling or declining benefits.

- **Write clearly.** If your form is unreadable, your enrollment may be delayed, or incorrect.
- **Don't forget the back side.** Missing or incomplete information will delay your enrollment.
- **Sign and date your enrollment form.** Remember to sign and date the form, even if you're declining benefits.

Helpful tips

- Your health care plan includes a network of providers you can visit for health care services. When you visit providers in this network, you will receive the best service rate. Call the provider information number for participating providers.
- Your name, identification number, medical group number and your group name, are used to identify you and your covered dependents' benefits.
- Your medical copays are listed for you and your providers.
- Your pharmacy coverage information is listed on the front of your card, and includes the Livinti customer service number and prescription copays.
- Please ensure that you precertify with medical management, if required.
- All claims should be submitted to Meritain Health at the address listed on the back of your card.
- You or your provider can call Meritain Health to verify eligibility of benefits or check on your claims status.
- You can call for information on a doctor or specialist who is close to you and serves your specific needs.

All eligible employees must complete the enrollment form, whether you're choosing this plan or declining benefits. Your enrollment form is included in the back of this packet.

Your Guide to Enrollment

The final step toward better balance and better living

After you've completed enrollment, your employer has approved it and after any waiting period has passed, your benefits will be effective.

Your Meritain Health ID card will be on its way to you soon. The card shows Meritain Health as your health plan administrator. Keep it in your wallet and carry it with you. If you misplace your ID card, use the Meritain Health mobile app to access your member website to get a copy of your ID on the go!

Sample ID card

Card front

Meritain Health an  company		Customer Service and Eligibility Inquiries 800.925.2272 www.MERITAIN.com	
Member		Medical Plan	
Lake County School District		Coverage: Aetna Network  Plan: Aetna Choice POS II	
Group #: 16035 Member: FIRST NAME LAST NAME Member ID: 123456789123 Division: 001 Dependent(s): DEPENDENT NAME 1 DEPENDENT NAME 2		RXBIN: 015433 RXPCN: SSN RXGRP: 16035  www.liviniti.com Member: 800.710.9341 Pharmacy: 800.710.9341	
Generic \$20 Formulary \$40 Non-Formulary \$60			

Card back

Claims Submission	Eligibility
Mail ALL Claims & Correspondence to: Meritain Health PO Box 853921 Richardson, TX 75085-3921 EDI: Change Healthcare 41124 or McKesson/Relay Health 1708 or 4561	Call 800.925.2272 or visit www.MERITAIN.com for inquiries regarding eligibility, claims and plan benefits.
NY Electing	Precertification
Aetna participating Doctors and Hospitals are independent providers and are neither agents nor employees of Aetna.	For Precertification call: 800.242.1199. Failure to comply with your plan's precertification requirements may result in a reduction of benefits.
Contact 800.343.3140 for assistance in locating an In-Network Provider.	24-Hour Automated Customer Service: 800.566.9311 or www.MERITAIN.com
Printed:	 DOI INDEX #: 009



Convenient Tools and Resources

Your personalized member website

Once enrolled as a Meritain Health member, you will have access to the **Meritain Health member website**. When you log in, you'll find everything you need to know about your benefits—from eligibility, to enrollment, to what's covered. It's another way we're working with you to help you get the most from your benefits—so you can live a life that's balanced and informed.

Registration for the member website is easy

If you're already registered to access your online account, simply enter www.meritain.com into your browser and login from the homepage.

If you're not yet registered, it's OK. Registration is an easy three-step process.

1

Scan the QR code and click on the link to register or visit www.meritain.com. Then, in the top right corner, click *Register*.



2

Next, select *Member* under *I am a* and enter your group ID. You can find your group ID on the front of your member ID card. (If you are new to the plan, you will soon receive your member ID card in the mail.) Then, click *Continue*.

Please note: You may set up a login for yourself, as well as any children under age 18 who are covered by your plan. For privacy purposes, your spouse and dependents over the age of 18, covered by the plan, must each establish logins to access their individual information.

3

You will need to fill in your:

- Group ID (located on your member ID card).
- Member ID (located on your member ID card).
- Date of birth
- Name.
- Zip code.
- Email address.

You can then create a username and password. After that, you will be asked to confirm your email address—then you're done! The next time you log in, just use the same username and password.



Members have the right to ask their health plan to place restrictions on (i) the way the health plan uses or discloses their PHI for treatment, payment or health care operations; and (ii) the health plan's disclosure of their PHI to persons who may be involved in their health care or payment thereof (e.g., family members, or close friends).

Convenient Tools and Resources

Important plan contacts

What do you need help with?

In-network doctors or hospitals

Meritain Health Customer Service **1.800.925.2272**

Access your Meritain Health member website at
www.meritain.com

The Aetna Choice® POS II provider network

Aetna provider line **1.800.343.3140**

www.aetna.com/docfind/custom/mymeritain

My prescription drug benefits

Livinti Customer Service

1.800.710.9341

Precertification

Meritain Health Medical Management **1.800.242.1199**

Enrollment/benefit elections

Lake County School District

Human Resources representative

1.719.486.6811



Notes



Simple. Transparent. Versatile.

At Meritain Health®, we're creating unrivaled connections.

Follow us:  @meritainhealth |  Meritain Health

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Meritain Health®
an  **aetna** company



Lake County School District



40% OFF

additional complete pair of prescription eyeglasses

20% OFF

non-covered items, including non-prescription sunglasses

Find an eye doctor (Insight Network)

- 866.804.0982
- eyemed.com
- EyeMed Members App
- For LASIK, call 1.800.988.4221

Heads Up

You may have additional benefits.

Log into eyemed.com/member to see all plans included with your benefits.

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES		
Exam	\$10 copay	Up to \$40
Retinal Imaging	Up to \$39	Not covered
CONTACT LENS FIT AND FOLLOW-UP		
Fit and Follow-up - Standard	Up to \$40	Not covered
Fit and Follow-up - Premium	10% off retail price	Not covered
FRAME		
Frame	\$0 copay; 20% off balance over \$130 allowance	Up to \$91
LENSES		
Single Vision	\$25 copay	Up to \$30
Bifocal	\$25 copay	Up to \$50
Trifocal	\$25 copay	Up to \$70
Lenticular	\$25 copay	Up to \$70
Progressive - Standard	\$90 copay	Up to \$50
Progressive - Premium Tier 1 - 3	\$110 - 135 copay	Up to \$50
Progressive - Premium Tier 4	\$90 copay; 20% off retail price less \$120 allowance	Up to \$50
LENS OPTIONS		
Anti Reflective Coating - Standard	\$45	Not covered
Anti Reflective Coating - Premium Tier 1 - 2	\$57 - 68	Not covered
Anti Reflective Coating - Premium Tier 3	20% off retail price	Not covered
Photochromic - Non-Glass	\$75	Not covered
Polycarbonate - Standard	\$40	Not covered
Scratch Coating - Standard Plastic	\$15	Not covered
Tint - Solid and Gradient	\$15	Not covered
UV Treatment	\$15	Not covered
All Other Lens Options	20% off retail price	Not covered
CONTACT LENSES		
Contacts - Conventional	\$0 copay; 15% off balance over \$130 allowance	Up to \$130
Contacts - Disposable	\$0 copay; 100% of balance over \$130 allowance	Up to \$130
Contacts - Medically Necessary	\$0 copay	Up to \$210
OTHER		
Hearing Care from Amplifon Network	Up to 64% off hearing aids; call 1.877.203.0675	Not covered
LASIK or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered
FREQUENCY	ALLOWED FREQUENCY - ADULTS	ALLOWED FREQUENCY - KIDS
Exam	Once every 12 months from the date of service	Once every 12 months from the date of service
Lenses	Once every 24 months from the date of service	Once every 24 months from the date of service
Frame	Once every 24 months from the date of service	Once every 24 months from the date of service
Contact Lenses	Once every 24 months from the date of service	Once every 24 months from the date of service

(Plan allows the member to receive either contacts and frame, or frame and lens services.)

Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy. Allowances provide no remaining balance for future use within the same Benefit Frequency. Some provisions, benefits, exclusions or limitations listed herein may vary by state. No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; Refraction, when not provided as part of a Comprehensive Eye Examination; services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment; safety eyewear; solutions, cleaning products or frame cases; non-prescription sunglasses; plano (non-prescription) lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices; services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer. Member receives a 20% discount on items not covered by the plan at In-Network locations. Discount does not apply to Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see online provider locator to determine which participating providers have agreed to the discounted rate. Discounts on vision materials may not be applicable to certain manufacturers' products. The Plan reserves the right to make changes to the products on each tier and the member out-of-pocket costs. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Service and amounts listed above are subject to change at any time. Discounts are not insured benefits. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, Policy number VC-19, form number M-9083, or Policy number VC-146, form number M-9184, in New York underwritten by Fidelity Security Life Insurance Company of New York, Policy Number VCN-1, form number MN-1, or Policy Number VCN-19, form number MN-28.



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.meritain.com or call (719) 486-6800. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call Meritain Health, Inc. at (800) 925-2272 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	For participating <u>providers</u> : \$1,000 person / \$2,000 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. For participating <u>providers</u> : <u>Preventive care</u> , <u>emergency medical transportation</u> , <u>emergency room care</u> , inpatient and outpatient hospital care, <u>urgent care</u> , initial prenatal visit, routine eye exam, outpatient lab services, <u>rehabilitation services</u> , and office visits are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	For participating <u>providers</u> : \$3,000 person / \$6,000 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance billing</u> charges and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.aetna.com/docfind/custom/mymeritain or call (800) 343-3140 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .
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 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$40 <u>copay</u> /visit	Not Covered	<u>Copay</u> applies per visit regardless of what services are rendered. Includes telemedicine.
	<u>Specialist</u> visit	\$55 <u>copay</u> /visit	Not Covered	
	<u>Preventive care</u> / <u>screening</u> /immunization	No Charge	Not Covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for. Routine mammograms limited to 1 baseline ages 35-39; 1 per year ages 40-49; unlimited per year ages 50 and over.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$40 <u>copay</u> /visit (lab)/ \$50 <u>copay</u> /visit (x-ray)	Not Covered	-----none-----
	Imaging (CT/PET scans, MRIs)	\$500 <u>copay</u> /visit	Not Covered	-----none-----
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.liviniti.com	Generic drugs	\$20 <u>copay</u> (retail)/ \$40 <u>copay</u> (mail order)	Not Covered	<u>Deductible</u> does not apply. Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription); 30-day supply (<u>specialty drugs</u>). The <u>copay</u> applies per prescription. There is no charge for preventive drugs. Dispense as Written (DAW) provision applies. <u>Specialty drugs</u> must be obtained from the specialty pharmacy program <u>network</u> . Certain <u>specialty drugs</u> are eligible for <u>copay</u> assistance programs through CVS True Accumulation Program. Step therapy provision applies. <u>Preauthorization</u> recommended for injectables costing over \$2,000 per drug per month.
	<u>Formulary</u> brand drugs	\$40 <u>copay</u> (retail)/ \$80 <u>copay</u> (mail order)	Not Covered	
	Non- <u>formulary</u> brand drugs	\$60 <u>copay</u> (retail)/ \$120 <u>copay</u> (mail order)	Not Covered	
	<u>Specialty drugs</u>	\$20 <u>copay</u> (generic)/ \$40 <u>copay</u> (<u>formulary</u>)/ \$60 <u>copay</u> (non- <u>formulary</u>)	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$750 <u>copay</u> /occurrence	Not Covered	<u>Preauthorization</u> recommended for certain surgeries, including infusion therapy costing over \$2,000 per drug per month. See your <u>plan</u> document for a detailed listing.
	Physician/surgeon fees	20% <u>coinsurance</u>	Not Covered	
If you need immediate medical attention	<u>Emergency room care</u>	\$250 <u>copay</u> /visit	\$250 <u>copay</u> /visit	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits for <u>emergency services</u> . <u>Copay</u> is waived if admitted to the hospital.
	<u>Emergency medical transportation</u>	\$250 <u>copay</u> /trip (ground and air)	\$250 <u>copay</u> /trip (air)/ Not Covered (ground)	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits for air ambulance.
	<u>Urgent care</u>	\$50 <u>copay</u> /visit	Not Covered	<u>Copay</u> applies per visit regardless of what services are rendered.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$1,000 <u>copay</u> /admission	Not Covered	<u>Preauthorization</u> recommended.
	Physician/surgeon fees	20% <u>coinsurance</u>	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 <u>copay</u> /visit (office visits)/ 20% <u>coinsurance</u> (all other outpatient)	Not Covered	Includes telemedicine.
	Inpatient services	\$1,000 <u>copay</u> /admission (facility)/ 20% <u>coinsurance</u> (professional fees)	Not Covered	<u>Preauthorization</u> recommended.
If you are pregnant	Office visits	No Charge (\$40 <u>copay</u> for initial visit)	Not Covered	<u>Preauthorization</u> recommended for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). <u>Cost sharing</u> does not apply to <u>preventive services</u> from a participating <u>provider</u> . Depending on the type of service, a <u>copay</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Baby counts towards the mother's expense.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	Not Covered	
	Childbirth/delivery facility services	\$1,000 <u>copay</u> /admission	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	Not Covered	Limited to 100 visits per year. <u>Preauthorization</u> recommended.
	<u>Rehabilitation services</u>	\$40 <u>copay</u> /visit	Not Covered	Physical, speech/hearing, aquatic & occupational therapy limited to a combined maximum of 20 visits per year. This maximum will not apply to speech therapy in association with autism.
	<u>Habilitation services</u>	Not Covered	Not Covered	This exclusion will not apply to expenses that are considered mental health or substance abuse services.
	<u>Skilled nursing care</u>	\$1,000 <u>copay</u> /admission	Not Covered	Limited to 45 days per year. <u>Preauthorization</u> recommended.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> recommended for any item in excess of \$1,500.
	<u>Hospice services</u>	20% <u>coinsurance</u>	Not Covered	Bereavement counseling is covered if received within 12 months of death and is limited to 6 visits per family per lifetime.
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	-----none-----
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)			
• Bariatric surgery • Cosmetic surgery • Dental care (Adult & Child) • Glasses (Adult & Child) • Habilitation services	• Hearing aids (age 19 and over) • Infertility treatment (except diagnosis) • Long-term care • Non-emergency care when traveling outside the U.S.	• Private-duty nursing (inpatient) • Routine foot care (except for metabolic or peripheral vascular disease) • Weight loss programs	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)			
• Acupuncture (30 visits per year) • Chiropractic care (20 visits per year)	• Hearing aids (1 aid every 5 years, up to age 19)	• Private-duty nursing (outpatient) • Routine eye care (Adult & Child)	

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or Lake County School District at (719) 486-6800. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or Lake County School District at (719) 486-6800.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-378-1179.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-378-1179.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-378-1179.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-378-1179.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,000
■ <u>Primary care physician coinsurance</u>	0%
■ Hospital (facility) <u>copayment</u>	\$1,000
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Primary care physician visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$1,400
Coinsurance	\$600
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,060

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,000
■ <u>Specialist copayment</u>	\$55
■ Hospital (facility) <u>copayment</u>	\$750
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Specialist office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$800
Copayments	\$1,200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,020

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,000
■ <u>Specialist copayment</u>	\$55
■ Hospital (facility) <u>copayment</u>	\$250
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$200
Copayments	\$1,100
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,300

The plan would be responsible for the other costs of these EXAMPLE covered services.



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE:** Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.meritain.com or call (719) 486-6800. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call Meritain Health, Inc. at (800) 925-2272 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	For participating <u>providers</u> : \$2,000 person / \$4,000 family For non-participating <u>providers</u> : \$4,000 person / \$8,000 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. For participating <u>providers</u> : <u>Preventive care</u> (all <u>providers</u>), initial prenatal visit, routine eye exam (all <u>providers</u>), outpatient lab services, <u>rehabilitation services</u> , and office visits are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	For participating <u>providers</u> : \$4,500 person / \$9,000 family For non-participating <u>providers</u> : \$9,000 person / \$18,000 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance billing</u> charges and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.aetna.com/docfind/custom/my_meritain or call (800) 343-3140 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$40 <u>copay</u> /visit	40% <u>coinsurance</u>	<u>Copay</u> applies per visit regardless of what services are rendered. Includes telemedicine.
	<u>Specialist</u> visit	\$40 <u>copay</u> /visit	40% <u>coinsurance</u>	
	<u>Preventive care</u> / <u>screening</u> /immunization	No Charge	10% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for. Routine mammograms limited to 1 baseline ages 35-39; 1 per year ages 40-49; unlimited per year ages 50 and over.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$40 <u>copay</u> /visit (lab)/ 20% <u>coinsurance</u> (x-ray)	40% <u>coinsurance</u>	-----none-----
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----none-----
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.liviniti.com	Generic drugs	\$20 <u>copay</u> (retail)/ \$40 <u>copay</u> (mail order)	Not Covered	<u>Deductible</u> does not apply. Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription); 30-day supply (<u>specialty drugs</u>). The <u>copay</u> applies per prescription. There is no charge for preventive drugs. Dispense as Written (DAW) provision applies. <u>Specialty drugs</u> must be obtained from the specialty pharmacy program <u>network</u> . Certain <u>specialty drugs</u> are eligible for <u>copay</u> assistance programs through CVS True Accumulation Program. Step therapy provision applies. <u>Preauthorization</u> recommended for injectables costing over \$2,000 per drug per month.
	<u>Formulary</u> brand drugs	\$40 <u>copay</u> (retail)/ \$80 <u>copay</u> (mail order)	Not Covered	
	Non- <u>formulary</u> brand drugs	\$60 <u>copay</u> (retail)/ \$120 <u>copay</u> (mail order)	Not Covered	
	<u>Specialty drugs</u>	\$20 <u>copay</u> (generic)/ \$40 <u>copay</u> (<u>formulary</u>)/ \$60 <u>copay</u> (non- <u>formulary</u>)	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> recommended for certain surgeries, including infusion therapy costing over \$2,000 per drug per month. See your <u>plan</u> document for a detailed listing.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits.
	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> recommended.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 <u>copay</u> /visit (office visit)/ 20% <u>coinsurance</u> (all other outpatient)	40% <u>coinsurance</u>	Includes telemedicine.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> recommended.
If you are pregnant	Office visits	20% <u>coinsurance</u> (\$40 <u>copay</u> for initial visit)/ No Charge (lab)	40% <u>coinsurance</u>	<u>Preauthorization</u> recommended for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). <u>Cost sharing</u> does not apply to <u>preventive services</u> from a participating <u>provider</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Baby counts towards the mother's expense.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 100 visits per year. <u>Preauthorization</u> recommended.
	<u>Rehabilitation services</u>	\$40 <u>copay</u> /visit	40% <u>coinsurance</u>	Physical, speech/hearing, aquatic & occupational therapy limited to a combined maximum of 20 visits per year. This maximum will not apply to speech therapy in association with autism. Coverage for speech therapy is allowed for Covered Persons up to age 19, without regard to diagnosis. Additional calendar year visits may be available when medically necessary.
	<u>Habilitation services</u>	Not Covered	Not Covered	This exclusion will not apply to expenses that are considered mental health or substance abuse services.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 45 days per year. <u>Preauthorization</u> recommended.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> recommended for any item in excess of \$1,500.
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Bereavement counseling is covered if received within 12 months of death and is limited to 6 visits per family per lifetime.
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	-----none-----
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded</u> services.)			
• Bariatric surgery • Cosmetic surgery • Dental care (Adult & Child) • Glasses (Adult & Child) • Habilitation services	• Hearing aids (age 19 and over) • Infertility treatment (except diagnosis) • Long-term care • Non-emergency care when traveling outside the U.S	• Private-duty nursing (inpatient) • Routine foot care (except for metabolic or peripheral vascular disease) • Weight loss programs	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (30 visits per year)
- Hearing aids (1 aid every 5 years, up to age 19)
- Private-duty nursing (outpatient)
- Chiropractic care (20 visits per year)
- Routine eye care (Adult & Child)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or Lake County School District at (719) 486-6800. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or Lake County School District at (719) 486-6800.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-378-1179.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-378-1179.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-378-1179.

Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-378-1179.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Primary care physician coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Primary care physician visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$500
Coinsurance	\$1,900
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,460

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist copayment</u>	\$40
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Specialist office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$800
Copayments	\$1,200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,020

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist copayment</u>	\$40
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$300
Coinsurance	\$20
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,320

The plan would be responsible for the other costs of these EXAMPLE covered services.



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.meritain.com or call (719) 486-6800. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call Meritain Health, Inc. at (800) 925-2272 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	For participating <u>providers</u> : \$3,000 person / \$6,000 family For non-participating <u>providers</u> : \$6,000 person / \$12,000 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u>?	Yes. For participating <u>providers</u> : <u>Preventive care</u> and routine eye exam are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	For participating <u>providers</u> : \$6,000 person / \$12,000 family For non-participating <u>providers</u> : \$12,000 person / \$24,000 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance billing</u> charges and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.aetna.com/docfind/custom/mymeritain or call (800) 343-3140 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

Is a Health Savings Account (HSA) available under this <u>plan</u> option?	Yes.	An HSA is an account that may be set up by you or your employer to help you plan for current and future health care costs. You may make contributions to the HSA up to a maximum amount set by the IRS.
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 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Includes telemedicine.
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Preventive care</u> / <u>screening</u> /immunization	No Charge	40% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for. Routine mammograms limited to 1 baseline ages 35-39; 1 per year ages 40-49; unlimited per year ages 50 and over.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----none-----
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----none-----
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.liviniti.com	Generic drugs	20% <u>coinsurance</u>	Not Covered	Major medical <u>deductible</u> applies. Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription); 30-day supply (<u>specialty drugs</u>). The <u>copay</u> applies per prescription. There is no charge for preventive drugs. Dispense as Written (DAW) provision applies. <u>Specialty drugs</u> must be obtained from the specialty pharmacy program <u>network</u> . Certain <u>specialty drugs</u> are eligible for <u>copay</u> assistance programs through CVS True Accumulation Program. Step therapy provision applies.
	<u>Formulary</u> brand drugs	20% <u>coinsurance</u>	Not Covered	
	Non- <u>formulary</u> brand drugs	20% <u>coinsurance</u>	Not Covered	
	<u>Specialty drugs</u>	20% <u>coinsurance</u>	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
				<u>Preauthorization</u> recommended for injectables costing over \$2,000 per drug per month.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> recommended for certain surgeries, including infusion therapy costing over \$2,000 per drug per month. See your <u>plan</u> document for a detailed listing.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits.
	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> recommended.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Includes telemedicine.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> recommended.
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> recommended for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). <u>Cost sharing</u> does not apply to <u>preventive services</u> from a participating <u>provider</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Baby does not count toward the mother's expense; therefore the family <u>deductible</u> amount may apply.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 100 visits per year. <u>Preauthorization</u> recommended.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Physical, speech/hearing, aquatic & occupational therapy limited to a combined maximum of 20 visits per year. This maximum will not apply to speech therapy in association with autism. Coverage for speech therapy is allowed for Covered Persons up to age 19, without regard to diagnosis. Additional calendar year visits may be available when medically necessary.
	<u>Habilitation services</u>	Not Covered	Not Covered	This exclusion will not apply to expenses that are considered mental health or substance abuse services.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 45 days per year. <u>Preauthorization</u> recommended.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> recommended for any item in excess of \$1,500.
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Bereavement counseling is covered if received within 12 months of death and is limited to 6 visits per family per lifetime.
If your child needs dental or eye care	Children's eye exam	No Charge	40% <u>coinsurance</u>	-----none-----
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)			
• Bariatric surgery • Cosmetic surgery • Dental care (Adult & Child) • Glasses (Adult & Child) • Habilitation services	• Hearing aids (age 19 and over) • Infertility treatment (except diagnosis) • Long-term care • Non-emergency care when traveling outside the U.S	• Private-duty nursing (inpatient) • Routine foot care (except for metabolic or peripheral vascular disease) • Weight loss programs	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (30 visits per year)
- Hearing aids (1 aid every 5 years, up to age 19)
- Private-duty nursing (outpatient)
- Chiropractic care (20 visits per year)
- Routine eye care (Adult & Child)

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Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$3,000
■ <u>Primary care physician coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Primary care physician visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,000
Copayments	\$0
Coinsurance	\$1,900
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,960

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$3,000
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Specialist office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,000
Copayments	\$0
Coinsurance	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$3,520

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$3,000
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

The plan would be responsible for the other costs of these EXAMPLE covered services.

Ready to live your best EyeMed life?

There's so much more to your vision benefits than copays and coverage. Get ready to see the good stuff for yourself.

Your network is the place to start

See who you want, when you want. You have thousands of providers to choose from – independent eye doctors, your favorite retail stores, even online options.

Keep your eyes open for extra discounts

Members already save an average 71% off retail using their EyeMed benefits,¹ but our long list of special offers takes benefits even further.

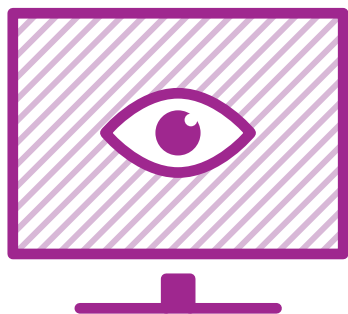
Remember, you're never alone

We're always here to help you use your benefits like a pro. Stay in-the-know with text alerts or healthy vision resources from the experts. If it can make benefits easier for you, we do it.

¹Based on weighted average of sample transactions; EyeMed Insight network/\$10 exam copay/\$10 materials copay/\$120 frame or contact lens allowance.



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Med



Create a member account at eyemed.com

Everything is right there in one spot. Check claims and benefits, see special offers and find an eye doctor – search for one with the hours, location and brands you want. For maximum mobility, try the EyeMed Members App (Google Play or App Store).

INDEPENDENT
PROVIDER
NETWORK



LENSCRAFTERS®

PEARLE
VISION

OPTICAL™

¿Listo para vivir la mejor experiencia con EyeMed?

Hay muchos beneficios más para la vista además de los copagos y la cobertura. Prepárese para ver los beneficios que le esperan.

Su red es el lugar para comenzar

Vea a quien quiera, cuando quiera. Tiene miles de proveedores para elegir: oftalmólogos independientes, sus tiendas minoristas favoritas y hasta opciones en línea.

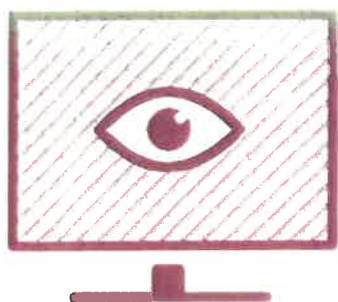
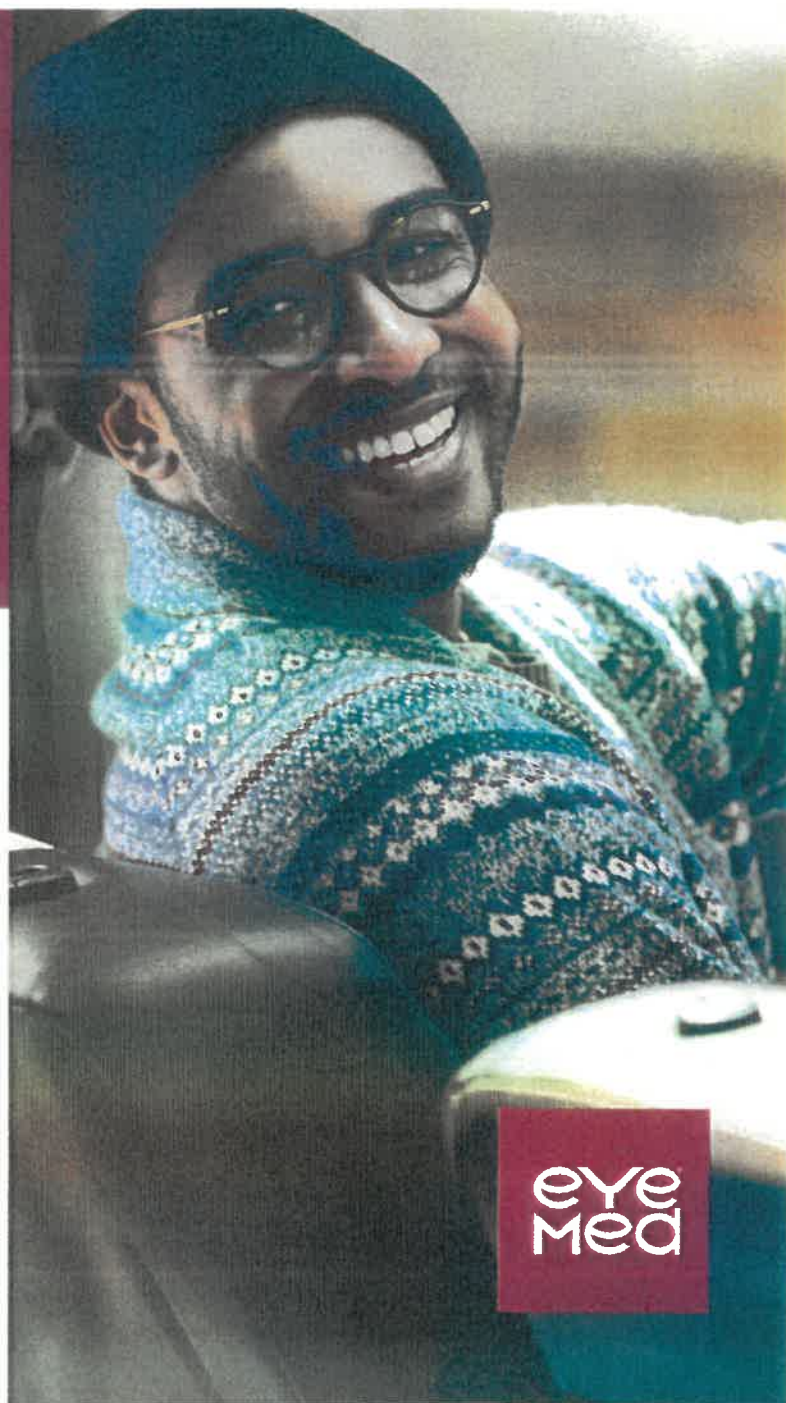
Esté atento a los descuentos adicionales

Los afiliados ya ahorran en promedio un 71% de descuento del precio de venta con los beneficios de EyeMed,¹ pero nuestra larga lista de ofertas especiales aporta aún más beneficios.

Recuerde: usted nunca está solo

Siempre estamos aquí para ayudarlo a usar sus beneficios como un profesional. Manténgase informado con alertas de texto y recursos para una vista sana por parte de los expertos. Si podemos facilitar los beneficios para usted, lo haremos.

¹Con base en el promedio ponderado de las transacciones de ejemplo; red de EyeMed Insight/copago de examen de \$10/copago de materiales de \$10/asignación de armazón o lentes de contacto de \$120.



Cree una cuenta de afiliado en eyemed.com

Todo está allí, en un solo lugar. Revise reclamos y beneficios, vea las ofertas especiales y encuentre un oftalmólogo: busque uno según el horario, la ubicación y las marcas que desee. Para máxima movilidad, pruebe la aplicación EyeMed Members (en Google Play o la App Store).

INDEPENDENT
PROVIDER
NETWORK



LENSCRAFTERS

PEARLE
VISION

OPTICAL

Delta Dental PPO plus Premier LAKE COUNTY SCHOOL DISTRICT – GROUP # 12558

CALENDAR YEAR MAXIMUM BENEFIT			\$1,750 per individual	
CALENDAR YEAR DEDUCTIBLE Applies to Basic and Major			Individual Deductible - \$ 50.00 Family Deductible - \$150.00	
PPO Dentist	PREMIER Dentist	OON Dentist	COVERED SERVICES	BENEFIT INFORMATION
DIAGNOSTIC AND PREVENTIVE SERVICES				
100%	100%	100%	Oral Exams and Cleanings	Twice each in a 12-month period. Two additional cleanings for special needs
			Sealants	Once per tooth for permanent molars in children through age 14
			Bitewing X-Rays	Once in a 12-month period
			Full Mouth X-Rays	Once in a 60-month period
			Fluoride	Twice in a 12-month period, through age 15
			Space Maintainers	Children through age 13
BASIC SERVICES – DEDUCTIBLE APPLIES				
80%	80%	80%	Fillings	Once per tooth in a 12-month period; amalgam fillings on back teeth; composite (white) fillings on front teeth
			Simple Extraction	
			Oral Surgery (General Anesthesia)	
			Endodontics/Periodontics	
MAJOR SERVICES – DEDUCTIBLE APPLIES				
50%	50%	50%	Crowns / Implants	Once per tooth in a 60-month period
			Dentures/Bridges	One in a 60-month period, only when an existing prosthesis cannot be made serviceable. Fixed bridges or removable partials are not a benefit for children under age 16
ORTHODONTICS - \$2,000 LIFETIME MAXIMUM				
50%	50%	50%	Children to age 19; \$2,000 lifetime maximum	

You are enrolled in a Delta Dental PPO plus Premier plan. You and your family members may visit any licensed dentist, but will enjoy the greatest out-of-pocket savings if you see a Delta Dental PPO dentist. There are three levels of dentists to choose from.

PPO Dentist - Payment is based on the PPO dentist's allowable fee, or the actual fee charged, whichever is less.

Premier Dentist - Payment is based on the Premier Maximum Plan Allowance (MPA), or the fee actually charged, whichever is less.

Out-of-Network Dentist – Payment is based on the out-of-network Maximum Plan Allowance (MPA). Members are responsible for the difference between the out-of-network MPA and the full fee charged by the dentist. You will receive the best benefit by choosing a PPO dentist.

Open Enrollment applies. Members may add coverage once per year.

This is a brief description of services covered under your dental plan. Please refer to the Employee Benefit Booklet for full plan details. If differences exist between this summary and the Employee Benefit Booklet, the Employee Benefit Booklet will govern.

Delta Dental of Colorado Customer Service: 1.800.610.0201 - customer_service@ddpco.com. Find us online at www.deltadentalCO.com.

BRINGING IT ALL INTO FOCUS

Time for a little Q&A

A LOOK AT THE BENEFITS

What exactly do my EyeMed benefits cover?

If you're thinking about EyeMed, you'll want to connect with your employer to learn about the benefit options. Already a member? The easiest way to find your benefit information is to create a member account on eyemed.com or grab the EyeMed Members App (App Store or Google Play).

Does EyeMed offer any extra discounts?

We sure do. At participating in-network providers, members get 40% off an extra pair of eyeglasses or 20% off a partial pair (lenses only or frames only).^{*} You also get 20% off non-prescription sunglasses and accessories, and discounts on LASIK laser vision correction. Call 1.800.988.4221 to find a LASIK location near you.

Can I use EyeMed benefits online?

Instantly apply your in-network benefits at checkout, with free shipping, free returns and no paperwork at these participating providers: lenscrafters.com, targetoptical.com, ray-ban.com, glasses.com and contactsdirect.com.

Can I get the same kind of care with a retail provider as I can with an independent doctor?

Many optometrists share space with a retail optical store, but operate a separate practice. All of them, wherever they practice, must meet the same state licensing and credentialing requirements. One advantage of using a vision carrier, like EyeMed, is that credentials of every in-network eye doctor are thoroughly examined and verified, so you can feel confident you're getting access to qualified eye doctors.

MEMBER HOW-TO TIPS

How do I use my benefits?

At EyeMed, we're all about easy. Just choose an in-network eye doctor from our Enhanced Provider Search, schedule your visit and go in for care or eyewear. You don't even need your ID card – just give them your name and birthday. When you stay in-network, we'll handle all the paperwork.

How do I find an eye doctor in my network?

The Enhanced Provider Search on Member Portal and the EyeMed Members App has thousands of in-network eye doctors to choose from. Filter your search to find ones near you with the brands, hours and services you most want.



eyeMed

How do I get on-the-go access?

The EyeMed Members App can do almost everything that Member Portal can. Find an eye doctor, set an appointment, review your benefits, check claims, find special offers, show your ID card—even store your vision prescriptions and set exam reminders. Download it through the App Store or Google Play.

How do I submit a claim?

When you see one of our in-network eye doctors, you won't have to; we take care of all the paperwork. By the way, you'll save money by staying in-network, too. If you need an out-of-network claim form, log into your member account to find one.

How do I get an ID card replacement or extra cards?

If you lose your card or need extras for your family, log into eyemed.com to print a replacement, or use your digital ID on the app. Here's a tip: you don't even need the card when you visit your eye doctor.

VISION AND YOUR HEALTH

I don't wear glasses and can see fine. Do I still need an eye exam?

Getting an eye exam isn't just about needing glasses. It's also about your health. An eye exam can detect eye health problems like glaucoma or cataracts, but it can also help identify early signs of serious diseases, like high blood pressure, diabetes and high cholesterol—just to name a few.¹

How often should I get an eye exam?

Vision changes can happen slowly—you may not even notice it. Annual eye exams are a good rule of thumb unless your doctor suggests more frequent checks; we suggest making it part of your regular preventive care routine.

At what age should my child first visit the eye doctor?

The American Optometric Association recommends a first eye exam between 6 months and 1 year of age.² The doctor may check for nearsightedness, farsightedness, astigmatism, amblyopia (or "lazy eye"), proper eye movement and eye alignment, and how the eye reacts to light and darkness. They also recommend an exam between the ages of 3 and 5, and every year after that.

My child gets a vision screening at school, so there's no need for an eye exam, right?

A vision screening does not take the place of a comprehensive eye exam. School screenings generally check for color blindness and your child's ability to see far away. A comprehensive exam will evaluate the entire structure of the eye.

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Thinking of becoming a member? Learn more at enroll.eyemed.com

Looking to stay healthy with vision? Learn how at eyesiteonwellness.com

Already a member? Manage benefits at eyemed.com

*Discounts are for in-network providers only. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Additional limitations and exclusions may apply. Log into your member account for full details. ¹ "5 Health Problems Eye Exams Can Detect," YourSightMatters.com, March, 2016. ² Comprehensive pediatric eye and vision examination"; (2017 guideline brief); American Optometric Association; <https://www.aoa.org/Documents/AOA%20Executive%20Summary%20Pediatric%20Eye%20Exam%20Guidelines%20Revised%2003.05.18.pdf>

ENFÓQUELO TODO

Es momento de una sesión de preguntas y respuestas

UN VISTAZO A LOS BENEFICIOS

¿Qué cubren exactamente mis beneficios de EyeMed?

Si está considerando unirse a EyeMed, deseará comunicarse con su empleador para conocer las opciones de beneficios. ¿Ya está afiliado? La forma más fácil de encontrar información sobre sus beneficios es crear una cuenta de afiliado en eyemed.com o descargar la aplicación EyeMed Members (en la App Store o Google Play).

¿Ofrece EyeMed algún descuento adicional?

Por supuesto que sí. En proveedores participantes de la red, los afiliados obtienen un 40 % de descuento en un par adicional de anteojos o un 20 % de descuento en un par parcial (solo en lentes o solo en armazones)*. También obtendrá un 20 % de descuento en lentes de sol sin receta y en accesorios, así como descuentos en corrección de la vista con láser LASIK. Llame al 1.800.988.4221 para encontrar una ubicación LASIK cerca de usted.

¿Puedo usar los beneficios de EyeMed en línea?

Aplice al instante sus beneficios dentro de la red al momento de pagar, con envío gratis, devoluciones gratuitas y sin completar documentos en estos proveedores participantes: lenscrafters.com, targetoptical.com, ray-ban.com, glasses.com y contactsdirect.com.

¿Puedo recibir el mismo tipo de atención con un proveedor minorista que con un médico independiente?

Varios optometristas comparten su espacio con una tienda óptica minorista, pero trabajan en consultorios separados. Todos ellos, independientemente de dónde trabajen, deben cumplir los mismos requisitos para obtener la licencia y la acreditación estatales. Una de las ventajas de contar con un proveedor de la vista, como EyeMed, es que las acreditaciones de cada oftalmólogo dentro de la red se examinan y se verifican minuciosamente, por lo que puede estar seguro de que tendrá acceso a oftalmólogos calificados.

CONSEJOS PRÁCTICOS PARA AFILIADOS

¿Cómo uso mis beneficios?

En EyeMed facilitamos todo. Simplemente elija un oftalmólogo de la red a través de nuestra búsqueda mejorada de proveedores, programe su visita y reciba la atención o los anteojos que necesita. Ni siquiera necesita su tarjeta de identificación. Solo brinde su nombre y su fecha de nacimiento. Cuando esté dentro de la red, nosotros administraremos todos los documentos.

¿Cómo encuentro un oftalmólogo en mi red?

La búsqueda mejorada de proveedores en el portal para afiliados y la aplicación EyeMed Members tiene miles de oftalmólogos dentro de la red entre los cuales elegir. Filtre su búsqueda para encontrar los más cercanos a usted según las marcas, los horarios y los servicios que desee.



¿Cómo obtengo acceso móvil?

La aplicación EyeMed Members permite hacer casi todo lo mismo que en el portal para afiliados. Encuentre un oftalmólogo, programe una cita, revise sus beneficios, revise reclamos, encuentre ofertas especiales, muestre su tarjeta de identificación e incluso guarde sus recetas de la vista y configure recordatorios de exámenes. Descárguela en la App Store o Google Play.

¿Cómo envío un reclamo?

Cuando vea a uno de nuestros oftalmólogos de la red, no tendrá que hacerlo. Nosotros nos encargamos de todos los documentos. Por cierto, también ahorrará dinero si permanece en la red. Si necesita un formulario de reclamo fuera de la red, inicie sesión en su cuenta de afiliado para encontrarlo.

¿Cómo obtengo un reemplazo de la tarjeta de identificación o una tarjeta adicional?

Si pierde su tarjeta o necesita tarjetas adicionales para su familia, inicie sesión en eyemed.com para imprimir una de reemplazo o use su identificación digital en la aplicación. Un dato: no necesitará la tarjeta cuando visite a su oftalmólogo.

LA VISTA Y SU SALUD

No uso anteojos y veo bien. ¿Aun así necesito un examen de la vista?

Hacerse un examen de la vista no solo implica la necesidad de anteojos. Se trata también de su salud. Un examen de la vista puede detectar problemas de salud visual, como glaucomas o cataratas, pero también puede ayudar a identificar los primeros signos de enfermedades graves, como la presión arterial alta, diabetes y colesterol alto, por nombrar algunas.¹

¿Con qué frecuencia debo hacerme un examen de la vista?

Los cambios en la vista pueden ocurrir lentamente, tal vez incluso ni los note. Los exámenes anuales de la vista son una buena regla de oro, a menos que su médico recomiende controles con más frecuencia. Nosotros sugerimos que formen parte de su rutina de cuidado preventivo regular.

¿A qué edad debe visitar mi hijo al oftalmólogo por primera vez?

La American Optometric Association recomienda realizar un primer examen de la vista a los 6 meses de edad y al año de edad.² El médico puede controlar la miopía, la hipermetropía, el astigmatismo, la ambliopía (u "ojo vago"), el movimiento correcto del ojo y la alineación ocular, y cómo reacciona el ojo a la luz y a la oscuridad. También recomienda un examen entre los 3 y 5 años de edad y después una vez al año.

Mi hijo recibe una evaluación de la vista en la escuela, por lo tanto, no es necesario un examen de la vista, ¿verdad?

Una evaluación de la vista no reemplaza a un examen integral de la vista. Las evaluaciones escolares, por lo general, controlan el daltonismo y la capacidad de su hijo para ver de lejos. Un examen integral evaluará toda la estructura ocular.



¿Está pensando en afiliarse? Obtenga más información en enroll.eyemed.com

¿Desea mantener una vista saludable? Conozca cómo hacerlo en eyesiteonwellness.com

¿Ya está afiliado? Administre sus beneficios en eyemed.com

*Los descuentos son solo para proveedores dentro de la red. Los beneficios no se pueden combinar con ningún descuento, oferta promocional ni otros planes de beneficios grupales. Se pueden aplicar limitaciones y exclusiones adicionales. Inicie sesión en su cuenta de afiliado para obtener más detalles. ¹ "5 Health Problems Eye Exams Can Detect" ("5 Problemas de Salud que se Pueden Detectar en los Exámenes de la Vista"), YourSightMatters.com, marzo de 2016. ² "Comprehensive pediatric eye and vision examination" (Evaluación pediátrica integral de los ojos y de la vista) (resumen de pautas 2017), American Optometric Association, <https://www.aoa.org/Documents/AOA%20Executive%20Summary%20Pediatric%20Eye%20Exam%20Guidelines%20Revised%2003.05.18.pdf>

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Lake County School District R-1

Eligibility	All full-time, active employees who are U.S. citizens or legal U.S. residents, working 30 or more hours per week, year-round who are performing the duties of their occupation on their last scheduled working day immediately preceding the effective date of the plan are eligible for insurance on that effective date.																				
Benefit Amounts	Your benefit coverage is \$20,000.																				
Reduction Schedule	Coverage reduces 35 percent at age 65 , 55 percent of the original amount at age 70 , 70 percent of the original amount at age 75 and 80 percent of the original amount at age 80 . Coverage terminates at retirement.																				
Accidental Death & Dismemberment	The amount shown is paid if a covered loss occurs within 180 days after accidental bodily injury or death, on or off the job. <table> <tr> <th><u>Loss of</u></th><th><u>Percentage of Amount Insured</u></th></tr> <tr> <td>Life</td><td>100%</td></tr> <tr> <td>Movement of both upper and lower limbs (Quadriplegia)</td><td>100%</td></tr> <tr> <td>Movement of three limbs (Triplegia)</td><td>75%</td></tr> <tr> <td>Movement of both lower limbs (Paraplegia)</td><td>75%</td></tr> <tr> <td>Movement of both upper and lower limbs on one side of the body (Hemiplegia)</td><td>50%</td></tr> <tr> <td>One hand, one foot or sight of one eye</td><td>50%</td></tr> <tr> <td>Speech or hearing</td><td>50%</td></tr> <tr> <td>Movement of one limb (Uniplegia)</td><td>25%</td></tr> <tr> <td>Thumb and index finger only</td><td>25%</td></tr> </table> Kansas City Life will not pay more than 100% of the amount insured for all losses sustained by an individual in one accident. Only the largest amount shown will be paid for injuries to the same limb resulting from any single accident.	<u>Loss of</u>	<u>Percentage of Amount Insured</u>	Life	100%	Movement of both upper and lower limbs (Quadriplegia)	100%	Movement of three limbs (Triplegia)	75%	Movement of both lower limbs (Paraplegia)	75%	Movement of both upper and lower limbs on one side of the body (Hemiplegia)	50%	One hand, one foot or sight of one eye	50%	Speech or hearing	50%	Movement of one limb (Uniplegia)	25%	Thumb and index finger only	25%
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Movement of one limb (Uniplegia)	25%																				
Thumb and index finger only	25%																				
Additional Benefits	• Waiver of Premium Benefit • Spouse Education Benefit • Conversion • Child Education • Accelerated Death Benefit • AD&D Benefits included: Seat Belt/Air Bag Benefit, Repatriation Benefit																				
Value Added Services	All enrolled employees will have 24-hour access to a travel assistance program, ID theft protection and beneficiary companion services through Generali Global Assistance (GGA).																				

This outline is intended to be a brief summary of your benefits and does not include all plan provisions and limitations. Details of your benefits may be found in your benefit booklet, provided to you at a later date. If there are any discrepancies between this outline and the group certificate, the group certificate governs.

Seguro de Vida



Kansas City Life
Insurance Company

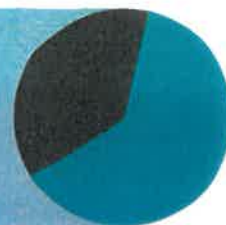


Group
Benefits

¿Tiene usted un cónyuge, hijos dependientes o un padre en su vida que depende de usted para su manutención? Si la respuesta es Sí, un seguro de vida podría ser la elección para usted.

En caso de la pérdida del proveedor de sueldo principal, 1 en 3 hogares tendría problemas inmediatos para pagar los gastos de vida.

Fuente: 2016 Insurance Barometer Study, Life Happens and LIMRA



93%

de los trabajadores en EE.UU. con beneficios de seguro de vida de su empleador cree que la mayoría de las personas necesitan seguro de vida.

Fuente: 2015 Life Insurance Awareness Month Fact Sheet, LIMRA

El seguro de vida continúa siendo una parte integral del paquete de beneficios de un empleador. Hoy, los empleados reconocen que tener un seguro de vida es una necesidad. Historias de seres queridos que dejan a sus familias sin protección financiera son cada vez más frecuentes. El plan de Seguro de Vida Grupal de Kansas City Life Insurance Company puede ayudarlo a obtener la protección y tranquilidad que necesita.

Tome esta oportunidad para revisar los beneficios de seguro de vida disponibles para usted de Lake County School District R-1.

RESUMEN DE SEGURO DE VIDA PARA

Todos los empleados activos a tiempo completo que trabajan 30 horas por semana durante todo el año, que son ciudadanos estadounidenses o legales de los Estados Unidos, residentes y están desempeñando las tareas de su ocupación en su último día de trabajo programado inmediatamente antes de la fecha de vigencia del plan son elegibles para el seguro en esa fecha de vigencia.

El beneficio de su cónyuge es \$20,000.

La cobertura se reduce 35 por ciento a los 65 años, 55 por ciento de la cantidad original a los 70 años, 70 por ciento de la cantidad original a los 75 años y 80 por ciento de la cantidad original a los 80 años. La cobertura termina al jubilarse.

**Puede variar según el estado.*

Beneficio de muerte accidental y desmembración (AD&D)

La cantidad mostrada se paga si una pérdida cubierta ocurre dentro de los 90 días después de una lesión corporal accidental o muerte, en o fuera del trabajo.

Pérdida de	Porcentaje de cantidad asegurada
Vida	100%
Movimiento de ambas extremidades superiores e inferiores (tetraplejía)	100%
Movimiento de tres extremidades (triplejía)	75%
Movimiento de ambas extremidades inferiores (paraplejía)	75%
Movimiento de ambas extremidades superiores e inferiores en un lado del cuerpo (hemiplejía)	50%
Una mano, un pie o vista en un ojo	50%
Habla o audición	50%
Movimiento de una extremidad (uniplejía)	25%
Dedo pulgar e índice únicamente	25%

Kansas City Life no pagará más del 100% de la cantidad asegurada para todas las pérdidas sostenidas por una persona en un accidente. Se pagará solo la cantidad mayor mostrada por lesiones de la misma extremidad resultantes de un solo accidente.

Beneficios adicionales

Beneficio de exención de prima

Conversión privilegiada

Beneficio de muerte acelerada

Beneficio de educación del cónyuge

Beneficio de educación de hijo(s)

Beneficios de AD&D incluyen: Beneficios de cinturón de seguridad/bolsa de aire, beneficio de repatriación

¡Inscríbase hoy!

Complete, firme y entregue su formulario de inscripción a Recursos Humanos y sepa que ha tomado un paso importante para ayudar a aliviar una carga financiera en caso de una muerte prematura.

Esta descripción tiene la intención de ser un resumen de sus beneficios y no incluye todas las provisiones y limitaciones del plan. Detalles de sus beneficios se encuentran en su certificado de cobertura, provisto a usted en una fecha posterior. Si existen discrepancias entre este resumen y el certificado grupal, el certificado grupal regirá.

Esta es únicamente una descripción breve y no es un contrato. La Póliza Maestra de Grupo determinará todos los derechos y beneficios. Para obtener los costos y más detalles de cobertura, incluyendo exclusiones, cualquier reducción o limitación y los términos bajo los cuales la póliza podría continuar en vigencia o ser descontinuada, consulte a su agente o escriba a la Compañía. La póliza es cancelable o renovable a discreción de la Compañía. La Compañía tiene el derecho de aumentar los montos de las primas. La cobertura no está disponible en todos los estados.

Póliza y certificado referenciados:
PJ136/CJ136



KANSAS CITY LIFE

GROUP BENEFITS

Asegurado por:
Kansas City Life Insurance Company
3520 Broadway
Kansas City, MO 64111-2565
P.O. Box 219425
Kansas City, MO 64121-9425
Teléfono gratis: 877-266-6767, ext. 8200
Fax: 816-531-4648
groupbenefits@kcliclife.com
www.kclicgroupbenefits.com

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